THE INTERACTION OF BLACK FAMILIES WITH THE TREATMENT OF THE BEHAVIORAL DISORDERED CHILD

A THESIS

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CHILDREN LEARN WHAT THEY LIVE

IF A CHILD LIVES WITH CRITICISM,
HE LEARNS TO CONDEMN.
IF A CHILD LIVES WITH HOSTILITY,
SHE LEARNS TO FIGHT.
IF A CHILD LIVES WITH RIDICULE,
HE LEARNS TO BE SHY.
IF A CHILD LIVES WITH SHAME,
SHE LEARNS TO FEEL GUILTY.
IF A CHILD LIVES WITH TOLERANCE,
HE LEARNS TO BE PATIENT.
IF A CHILD LIVES WITH ENCOURAGEMENT,
SHE LEARNS CONFIDENCE.
IF A CHILD LIVES WITH PRAISE,
HE LEARNS TO APPREICATE.
IF A CHILD LIVES WITH FAIRNESS,
SHE LEARNS JUSTICE.
IF A CHILD LIVES WITH SECURITY,
HE LEARNS TO HAVE FAITH.
IF A CHILD LIVES WITH APPROVAL,
SHE LEARNS TO LIKE HERSELF.
IF A CHILD LIVES WITH ACCEPTANCE AND FRIENDSHIP,
HE LEARNS TO FIND LOVE IN THE WORLD.

DOROTHY LAW NOLTE

This paper is dedicated to my children,
Jason and Regina with love.

ABSTRACT

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The Interaction of Black Families with the Treatment of the Behavioral/Disordered Child

This study hypothesized that there is no difference between the perception of family interaction by behavioral disordered children in Atlanta, Georgia and St. Thomas, Virgin Islands. A descriptive-comparative survey was used to obtain the data from the two identified groups of subjects. The following descriptive statistics were used to analyze data, frequences, tables, percentages, and measures of central tendency.

The results indicated that there was a consensus from both groups that parents seldom demonstrated physical affection. In addition, parents rarely told their child that he/she was loved. Findings also revealed that a high percentage of parents never went on family outings or set aside time for family discussions.

CONCENTRATION: Comprehensive Health/Policy, Planning and Administration.

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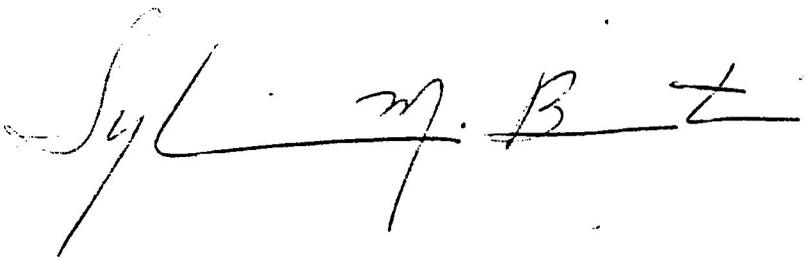

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CHAPTER I

INTRODUCTION

In recent years there has been a growing concern over the negative effects of labelling children. Social scientists have gathered much data that supports the self-fulfilling prophecy that occurs when parents and teachers impose negative labels on young children.

In a culture that historically holds little value for non-white persons, stereotyping has done a grave injustice to our children. In a society where a child is confronted by racism before he or she has a strong sense of self we can certainly expect to find high levels of inappropriate social emotional and physical behaviors.

Dr. Lendon Smith (1976) asserts that society is aware of the child's need to feel wanted and loved. He further states that it is society's responsibility to meet the needs that are so crucial in the early stages of development. Consequently, if a child is made to feel wanted and needed he/she will most likely respond to his/her environment in a mutually acceptable and satisfying manner.

Unfortunately there is very little accountability for society's responsibility to the Black child. There is also very little congruence between the dominant society's definition of socially acceptable behavior and the social environment that Black children are traditionally, exposed to. As a result of this incongruence the Black child is typically penalized for differing from the norm. Second the negative labelling often times takes the form of school

suspensions, truant warrants, mental health dispositions and other forms of social isolation.

The purpose of this sutdy is to determine whether perception of family interaction is the same among black youth's who have been labelled behavioral disordered. In an effort to establish findings that are based solely on subjects that are non-white, it was decided that data would be gathered in St. Thomas, Virgin Islands and Atlanta, Georgia.

HISTORICAL PERSPECTIVE

Background

What is the mental health status of the Black child and the Black family? In order to get a good picture as to who the Black family was and still is and to find out what role the Black child played within the family structure, one needs to look at it from a historical perspective.

The history of the Black family goes back to Africa. Billingsley (1968) quoted John Franklin as stating that the African family's life consisted of several features. First, family life was not primarily or even essentially the affair of two persons who happened to be married to each other. It united not just families but the whole network of extended kinship, who found it their jobs to be responsible for the family's development and well-being. Marriage could neither be entered into nor abandoned without substantial community support. Second, marriage and family life prior to colonization as among most tribe people, were enmeshed in centuries of traditional ritual custom and law. Third, family life was also workable and was the center of the African civilization. On the same note, the children were provided a quality of care and protection not common in modern socieites, for they belonged not only to their father and mother, but also, principally to the wider kinship group. They were well loved and affection was abundantly given because they were and are still considered the future of the African people.

Slavery

The African family, having been taken out of Africa and having been spread throughout the United States because of slavery, experienced social and psychological problems as well as a complete disruption of its cultural life. The culture of the African family was disrupted in that being forced as they were from Africa to the New World, the Africans were confronted with an alien culture of European genesis. Thus, unlike some of the later migrants, including the German, Irish, and Italians, the Africans were not moving into a society in which the historical norms and values and ways of life were familiar and acceptable. Secondly, they came from different tribes with very different languages, cultures, and traditions. Thirdly, they were brought to America by force unlike other immigrants and most importantly they came in chains. Therefore, whatever the nature of the cultural systems from which they came to which they were not free to engage in the natural process of acculturation. They were not only cut off from their previous culture, but they were not permitted to develop and assimilate into the new culture in ways that were unfettered and similar to the opportunities available to other immigrant groups. The African family was forced to adopt a life style that was in no way consistent with their African customs (Billingley, 1968).

The life of the Black child during slavery was a depressing one. The routine of the plantation prevented the lavishing of care upon the infant and in this regard, Blassingame (1978) stated that Frederick Douglass, did not remember seeing his mother until he was seven years

old, asserted that "the domestic hearth, with its holy lessons and precious endearments, is abolished in the case of a slave mother and her children." On many plantations women did not have enough time to prepare breakfast in the morning and were generally too tired to make much of a meal or give much attention to their children after a long day's labor. Booker T. Washington's mother was also typical when he stated that, "my mother... had little time to give to the training of the children during the day. She snatched a moment for our care in the morning before her work began, and at night after the day's work was done." At a very early stage of life, the child was placed in the hands of his/her elderly siblings. In some cases he/she was put to work at an early age or he/she was used as a scapegoat for and by white children. In either case the child was neglected, fed irregularly or improperly taken care of, and as a result suffered from a variety of illnesses and treated by ignorant mothers (who just did not know any better) or little more enlightened planters, they died in droves (Blassingame, 1979).

However, some children were properly taken care of by their families despite the hardship of slavery. Memories of Africa was used as an important device in the development of self-awareness in slave children. The reasoning behind bridging the past with present can help us to develop a better understanding of the Black child and the Black family's dilemma. Some of the children who survived slavery grew up having difficulty in relating to other people. Their children then followed in the same pattern to each other. Therefore, these children found other means or ways of getting or obtaining love, attention, etc. If acting

out, getting into trouble, etc. give them the attention they need or they want, so be it. The sadness of it all, is that these children were then diagnosed and are still being diagnosed "problem children." Instead, they were and are still being placed in institutions where attempts were and are being made to "modify their behavior."

Are these children really suffering from a behavioral disordered or are they just victims of needed love and attention? On the other hand, has any thought been given to the fact that the behavioral problem displayed by behavioral disordered children might and can be due to psychological, environmental, poor nutritional problems or any numerous of body chemistry imbalance.

The Black child is not readily tested by doctors for numerous reasons, instead they are treated for symptoms and not the underlying problem or cause.

Black children are often not given neurological workups. However, we often hear doctors, or other professionals say, "It is a phase that the child will out grow?" Or is it just the doctor's easy way out because he/she does not know what is going on? Why is it that so many children turn out so badly? Why does a cute, bright, happy little baby grow up to be delinquent? (Smith, 1976).

Religious sources claim if we turn to God, the problem will be solved. Psychiatrists say childhood experiences determine our adult personalities. Behaviorists believe we learn to be bad because someone important has reinforced our bad behavior. Social scientists may feel we

are stuck within our customs and norms. These were the words and thoughts of Dr. Lendon Smith, (1976) who feels that behavior is much more than a will full act displayed by the child.

Dr. Smith (1976), further asserts that maybe they are all correct, because there is a pattern in all this. He recognizes those infants who have a problem, those who are close to having a problem, or those who might later have a problem in adolescence or adulthood. Professionals can now identify those children who are more at risk for stress, sickness, nervousness, hyperactivity, enuresis, allergy, dyslexia, alcoholism, obesity, and other problems traditionally assumed to be psychologically or environmentally produced. Even though our knowledge is limited, there is now enough information about behavior, metabolism, and brain chemicals to be able to predict which infants and children are liable to develop maladaptive behavior.

Smith (1976), concludes that we are unable to prevent conception amongst unfit adults, and are aware that even the best of parents may be faced with the difficulty-to rear a child. Perhaps at present we had better not change the rules of the mating game, but concentrate on recogniing those infants and children most likely to run the risk of developing into problem people.

Early recognition is the key and not false diagnosing. We have the medical, nutritional, educational, and counseling skills now, but they are not being applied early enough or fully, enough to prevent fixed psychoses, emotion-draining neuroses, alcoholism, depressions, behavior disorder, drug addiction and plain dissatisfaction with life (Smith,

1976).

The future is ours to do something with, time will not change anything, but pass! The Black community has to start looking out for its future in the Black child. It is time for us to get involved in the "whats happening" of our children.

STATEMENT OF THE PROBLEM

During the prenatal period, before the American Black child is even conscious of its existence, the child is much more a victim of this society's adverse effects than any other American child. The unfortunate effects of slavery, past and present racial discrimination, and cultural deprivation, make themselves felt during this period when the very foundation of life is being laid. From the beginning of his/her creation, the Black child suffers both the emotional and physical consequences of the "Black condition" in America (Wilson, 1978).

A child regardless of its race, creed or color needs to know that his/her environment is complete with love, attention and trust. However, some children might feel that their parents have robbed them of these needs. Therefore, children tend to display certain behaviors that will elicit a response to their needs. There are many characteristics of behaviors that children display, but only one in particular was addressed in this study, and that is behavior disorder.

The term behavior disorder or problem behavior is defined as "any learned undesirable or self-defeating pattern of

behavior displayed by a child. Obviously, one's attitude about behavior is a reflection of one's individual values." Since there is considerable variability in personal values, there are great differences of opinion regarding the desirability of behavior. For example, a child's agressive behavior on the playground may be applauded by some adults and scorned by others. However, there is a general consensus that such behaviors as lying, cheating and stealing are undesirable (Twiford, 1979).

Behavior for all practical purposes is learned, and therefore, it can be altered through learning. There are several ways (paradigms) in which learning occurs and they will be briefly discussed later in the paper. Although it is somewhat unconventional to do so, the traditional diagnoses of childhood neuroses and personality (conduct) disorders will be meshed into the learning theory perspective. This approach is considered advantageous for several reasons. First, children's behavior patterns are usually transient and situational. It is unnecessary to label a child as neurotic when the problems is unstable to the extent that the term personality disorder is enduring, stable patterns of undesirable behavior. Second, psychologists and psychiatrists are increasingly avoiding the use of these labels. The terms neurosis and personality disorder do not adequately predict treatment strategies and prognoses for children. Additionally, mental health professionals recognize that an unfavorable stigma is associated with these labels. It is certainly in the best interest of the child to have a specific behavior rather than a neurosis. Finally, the medical model is not applicable to problems that are a result of learning. Learned, undesirable behavior is not a disease that can be cured through medical treatment (Twiford, 1979).

To take the words of Dr. Smith (1976) which states, it is important to note that all children learn differently, and we must be willing to accept differences as expressions of uniqueness and individuality. Don't force a way of life on a child that the nervous system is going to reject. Remember, the elbow bends only one way.

DEFINITIONS OF TERMS

BLACK FAMILY: In America, the Black family was observed as having two types of family structure: male-headed families or female-headed families. Such characterization is almost always followed by the assertion or assumption that male-headed families are stable and that the latter are more than twice as common among Blacks as among whites. Andrew Billingsley (1968) also added that this manner of characterizing the structure of Black family life has a number of implications. It underestimates the variations among Black families living under different basic conditions.

Billingsley (1968) further stated that here are three general categories of families: primary families, extended families, and augmented families. A family is commonly defined as "a group of persons related by marriage or ancestry, who live together in the same household. Nuclear families are confined to husband and wife and their own children, with no other members present. Extended families include other relatives or in-laws of the family head, sharing the same household with the nuclear family members. Augmented families include members not related to the family head who share the same household living arrangements with the nuclear family. Roughly two thirds of all Black families are nuclear families; a quarter are extended

and a tenth are augmented families.

Furthermore, within the framework of these categories, twelve different types of structure may be specified. In addition, this typology allows for the elaboration of subtypes within several of these twelve types of structure. The typology of the Black structures appear in Table 1, see appendix (Billingsley, 1968).

NUCLEAR FAMILIES

Within the nuclear family, three specific types of family structure may be observed. Type 1, the Incipient Nuclear Family, is composed of husband and wife living together in their own household with no children. In this group you tend to find young married couples who have not yet had time or economic security to start their family, older couples who have not been able or willing either to have their own children or to adopt others, and still other couples whose children have grown up and left the home. This type also includes a few families who minor children have been placed in foster homes or institutions because of illness or other incapacities of one or both parents. The incipient nuclear families offer an important potential for the care of children in the Black community, though there is some indication that among Black families those with some children already may be more willing to take in other children than those without children of their own (Billingsley,1968).

The second type of family structure within the nuclear family is the Simple Nuclear Family. This type consists of husband, wife and their own or adopted children living

together in their own household with no other members present. This is the traditional type of family structure in America and Europe (Billingsley, 1968).

The third type of family structure within the nuclear family is Attentuated Nuclear Family. This type of family structure has either a father or a mother-but not both living together with minor children in parent's own household and with no other persons present. The most frequent form is mother and children living together (Billingsley, 1968).

EXTENDED FAMILIES

According to Andrew Billingsley (1968) the members of the nuclear family all live together in their own house, every member being related to the head of the household either by marriage or birth. In the second category of family structures, other relatives are introduced into this nuclear household, making of it an extended family.

The types of extended families include: (a) the incipient extended family consisting of married couple with no children of their own who take in other relatives; (b) the simple extended family, consisting of married couple with their own children, who take in relatives; and (c) the attenuated extended family consisted of a single, abandoned, legally separated, divorce, or widowed mother or father living with his/her own children, who takes into the household other relatives. It is important to note, that there are four classes of relatives who can and often do come to live with Black families. These are (a) minor relatives, including grandchildren, nieces, nephews, cousins

and, (b) other adult relatives, (c) elders of the primary parents including particularly, aunts, and uncles; and finally (d) parents of both the primary family needs (Billingsley, 1968).

AUGMENTED FAMILIES

The third major category of families consists of families which have unrelated individuals living with them as roomers, boarders, lodgers, or other relatively long-term quests. Since these unrelated presons often exert major influence in the organization of Black families, this group of families, is referred to as "agumented families" (Billingsley, 1968).

The reasoning behind using such a wide range of definitions for the Black family is because of the complexity of the Black family network. Using one general definition would not have given a clear picture of the different components that exist between the Black family. The Black family does not necessarily consist of mother and father, but sometimes also includes the extended kinship and other non relatives.

BLACK COMMUNITY: Community unit, or a geographical area that is composed of Blacks who share common identification in a cultural heritage, common interest in the rights of its people; and an association of interest for its people. In either case, the problem of concern is how the members of these communities may come to be identified with, and share responsibility for, development of a community life which is alert and active in solving some of the problems which prevent it, and the larger society of which is a parent, from utilizing the riches which the humanities and

science, have made available to modern man (Ross, 1973).

TREATMENT: Any type of therapy such as individual, family, and academic therapy, etc., that will help the child and family to understand each other behavior.

BEHAVIOR DISORDER: Any learned undesirable or self-defeating pattern of behavior displayed by a child (Twiford, 1979).

INTERACTION: Includes the involvement of parents hugging, kissing, setting aside time for family discussions, going on family outings, etc.

CHILDREN: ages 6 - 13

CHAPTER II

REVIEW OF THE LITERATURE

According to Birmingham, Rogers, and Schmidt (1977) working with families is a challenging job but an important one. They implemented a parent involvement program in a hospital and school for children. The implementation took place in the Gaebler Children's Unit Hospital in Waltham, Massachusetts. The hospital provided both inpatient and daycare psychiatric services for children between the ages of six and sixteen (16). The Gaebler school, fully accredited by the Massachusetts Department of Education, is especially attuned to managing behavior and educating children who are in the 55-bed unit hospital who are automatically enrolled and in addition, 50 children commute daily from their homes in surrounding communities. The return to neighborhood public schools is always effected as soon as possible.

For professionals who work in state mental health hospitals and institutional schools, serving the deprived and depleted client who has become the rule rather than the exception. The combined trends of deinstitutionalization and increased budget cuts, limit those families and children who are under the most severe emotional distress. Most of those who use state services do so because they cannot afford treatment from the private sector who has excerised its option of refusing to serve them (Birmingham, Rogers, and Schmidt, 1977).

Often, the families whose children come into state hospital and school care facilities are those with longstanding,

rigid defense structures. The common social phenomenon of rejection of the depleted disorganzied, depressed, angry or acting-out family results in devastating isolation for that family unit, an isolation that usually further inhibits their adaptability and the process of socialization. When a child from such family enters his/her secondary social system (school, church, clinic, court) authorities are often at a loss as to how to reach the child and family. As a result, professional workers may feel frustrated, angry, and helpless and they may disipate their feelings by blaming the family who, after all created and shaped the child. Many professionals feel that parents are "unmotivated," "unworkable," "sabotaging" or even "hopeless." However, the feelings of the families are often mutual. Parents arrive at the hospital or school feeling overwhelmed and frightened by the prospect of their child living in a "mental institution" or going to school in a mental hosptial setting. They are feeling angry and frustrated by the agencies that are supposed to help their children. By the time the child comes to the Children's Unit, the family may have been involved with five to 10 different community agencies during the course of three to five years, each attempting to diagnose and treat children and family problems (Birmingham, Rogers, and Schmidt, 1977).

It is not suprising, then that once the child is accepted, the family may well be resistant to any further intervention effort particularly those resembling previous approaches. Consequently, the most crucial contact that families make with the hospital and school come within the first days and weeks of the child's admission. If parents do not have the opportunity to perceive and experience the atmosphere as caring, it is likely that their feelings of anxiety, fear, guilt, anger or failure will intensify. Feeling rejected and misunderstood, their response may be withdrawal

of their children from the unit, avoidance of further cooperation with the hospital and or school, alignment with the child against all treatment or education plans. (Birmingham, Rogers, and Schmidt, 1977).

A follow-up study undertaken by some members of the Social Service Department in 1969 indicated the families involved in the children's unit feel into four categories: those who made direct contact with the unit; those who came only for the one obligatory initial interview; those who had had regular contacts with the hospital or school but were involved with social services, and those who had had regular contacts with a caseworker and/ or ward parent group. Since the last group was relatively small, the members decided to explore ways of increasing the alternative services available to parents. They hoped that by implementing a parent involvement program more families would increase the Children's Unit responsiveness to their needs (Birmingham, Rogers, and Schmidt, 1977).

The Parent Involvement Program would not supplant any traditional programs: rather, it would enhance and broaden alternatives for families whose needs vary during their child's stay with the unit. Their goals are stated briefly below:

* To help parents see a possibily threatening institution as a group caring, knowledgeable professional people.
* To provide ways of facilitiating communication among children and between staff and parents.
* To make it possible for families' strengths to become immediately recognized, useable and maintained as a force to help their depression and despair.

* To provide a structure within which parents could develop and gain some insights and experience better ways of coping with situations (Birmingham, Rogers, and Schmidt, 1977).

The program turned out to be a success because the needs of the parents were considered in the planning of the program. Therefore, the parents felt that the program was concerned about who they were and what they had to contribute.

The involvement of the family is becoming an important component of early intervention for moderately and severely handicapped preschool children. Bricker and Casuso (1979) felt that parental programs should provide information and skills to parents that would assist them in becoming effective change agents with their handicapped child and knowledgeable consumers of services for the handicapped.

Bricker and Casuso (1979) also contend that the necessity of parental involvement is acknowledged by many professionals working with young handicapped children. The assistance and education of parents by early intervenionists and the inclusion of parents in these intervention program are accepted as necessary activities if the child is to make maximum developmental progress.

Unfortunately, the objective information available on the effects of parental involvement with the young handicapped child is minimal (Bronfenbrenner, 1975). Although early interventionists acknowledge the benefits derived from parental involvement, the direct effect on programmatic success has yet to be consistently and objectively documented in programs focusing on the more severely handi-

capped child (Bricker and Casuso, 1978; 1979).

Important as empirical demonstration may be, the question of whether or not to encourage the inclusion of families in such programs appears to have been answered by recent federal legislation. Public Law 94-142 (the Education for All Handicapped Children's Act of 1975) requires that the parents be included as an integral part of the child's educational program. The question, therefore, appears not to be whether families should be included but how they should be most effectively involved (Bricker and Casuso, 1979).

At the University of Miami, Mailman Center for Child Development, Debbies Institute, the early intervention programs housed in this center serve approximately 90 children on a daily basis who range in age from 10 to 60 months and have mild to profound impairments (Bricker; Siebert; and Casuso, 1979).

According to Bricker and Casuso (1979) there are six steps involved in operating or implementing a family involvement program. (Figure 2, shown in the appendix presents a schematic view of the steps a child and family go through from referral to exit from the program).

STEP I - Referral: Referral are received from a number of community agencies.

STEP II - INTAKE: The intake meeting has four objectives: (a) to provide information about the program to the family, (b) to seek information about the family, (c) to administer the Denver Developmental Screening Test, and (d) to obtain behavioral information about the child. At the termination

of the intake process the staff consult to make a decision on the child's placement. If is decided that the child does not meet criteria for any Debbie Institute program, the family is assisted in locating alternative resources. If the child is deemed appropriate he or she is tentatively enrolled then a home visit is scheduled.

STEP III - HOME VISIT: During the home visit the family is assisted in filling out demographic forms. An informal evaluation of the home in relation to the target child is also completed. Upon completion of this visit the child is formally enrolled in the program.

STEP IV - NEEDS ASSESSMENT/CONTRACTING SESSION: In this step the concern is geared towards helping the family understand the program's commitment to them and, in turn, their responsibilities to the program.

STEP V - EDUCATION AND CHILD ADVOCACY: Step V actually encompasses the intervention to be used with the family. The intervention can include two basic areas: education/advocacy and social service/counseling. The decisions made during the needs assessment/contracting period will participate in the nature of participation. Reassessment of needs is done systematically so the family has ample opportunity to change the level or nature of their participation.

STEP VI - YEARLY FOLLOW-UP: Once the child and his/her family terminates from the program a yearly follow-up is conducted to moniter the child's status in his or her current placement.

Bricker and Casuso (1979) finalized their article by saying that the success of early intervention and family involvement is dependent upon our ability to assist families in maintaining their handicapped young children within the home, with the provision that both the children and family members can lead reasonably happy productive lives.

Betty A. Sugarman (1979) stated that the admission of an emotionally disturbed child to a mental health facility is a time of crisis for parents who may feel confused and defeated as well as relieved. From intake through discharge, the social worker plays a key role as systematic advocate for parents and mediator between staff and family.

Edge, Strenecky, and McLoughlin (1979) felt that parents of handicapped children have not been utilized effectively in teaching their children academic or social behavior skills. Generally, school systems have ignored the potential resources and assurances that could be provided by parents of handicapped children. Therefore, the focal point of this article is to explore several ways in which parents of handicapped children can and should be involved in teaching their children appropriate behaviors in the home, school and community.

Parents have a right to be involved in educational programming for children. The education for all Handicapped Children Act of 1975 point out that parents must be involved in assisting educators in developing these educational programs. Furthermore, special educators have a responsibility to involve the parent in a successful parent-professional partnership (Edge, Strenencky, and McLoughlin, 1979).

If the parents can become effective teachers of their children, then the question that remains is, "what is the most effective way for the parent to become involve in assisting the child"? Ideally, parents could be taught to understand the specifies of cognitive, psychomotor and social-behavior development. However in a more realistic vein, parents should be involved in the maintenance of academic skills and the teaching of specific social behaviors.(Edge, Strenecky, and McLoughlin, 1979).

The teaching of social behavior skills remains in the major responsibility of the parent. However, parents are not taught how to deal with the teaching of social behavior. The basics of getting along with other seems to be taught vicariously and left to the fate of the environment. (Edge, Strenecky, and McLoughlin, 1979).

Edge, Strenecky, and McLoughlin, 1979) also pointed out that educators and parents of handicapped children are beginning to see the benefits of working together in developing programs for their children. Educators have begun to develop courses for the purpose of training professionals in working with parents. Parent education will encourage wider opportunities for more effective parent/child interaction.

It is conceivable that within the next 10 years, colleges and universities will be training parent specialists. These individuals will likely function in school settings for the purposes of fostering positive working relationship with parents and for training parents in child programming and management skills. It is believed that in the near future parents will play more active roles in systematic instruction of their children.

It is very evident, based on earlier studies that information about parent involvement were primarily brief reviews of professional observations. These studies tried to show that parental involvement or interaction programs, provided very effective therapy for the child and his/her family. Earlier studies made it clear that additional data needed to be gathered to prove that parental involement or interaction was very rewarding in the treatment of special children (i.e. Mental retarded, handicapped, emotional disordered, behavioral disordered). Consequently, later studies were much more detailed and validated that parental involvement or interaction can be very useful in working with special children.

Watt, Reardon, and Bass (1977) conducted a study on the readjustment of black, high risk adolescents to the community. Their study pointed out three issues: the first issues concerned the effects of labelling upon the adolescent's readjustment. Second, several variables were identified as influencing referrals for hospitalization, subsequent readjustment and discharge placement. The final issue dealt with the effects of the therapist's willingness to extend themselves to culturally different families.

A total of 169 adolescents were admitted from December, 1969, to February, 1974, 22 were black and came from South Central Los Angelos Treatment and research records were used to obtain demographic, referral program information, labelling of intellectual functioning prior to admission, referral source, length if hospitalization and degree of parental involvement. . . (Watt, Reardon, and Bass, 1977).

Written records were used by authors to classify families into four categories: (10) Involve (n=15): Parent(s) came for appointments, maintained telephone contact, took the patient home for weekend visits, and participated in disposition planning. (2) Occasional (n=4): Parent(s) came for appointment, on weekends. (3) Uninvolved (n=3): Parent(s) bought the patient to the hospital for admission but failed to come in for appointments, maintain telephone contact, or take the patient home for weekend visits on a regular basis. (4) telephone (n+1): Parent(s) were unable to come for appointments due to illness, lack of transportation or funds, but maintained telephone contact with the patient and therapists. (Watt, Reardon, and Bass, 1977).

Some parents who had to depend on a friend, relative, or neighbor to provide transportation could not commit themselves to regular appointments. Parent who had cars could not always afford gasoline or parking fees, and the hospital was unable to provide transportation or funds that might have alleviated these problems. Obtaining babysitters for siblings was another problem that affected the ability to participate. The misinterpretation of these reality factors as resistance and manipulative often reinforced rather than modified the parents' negative perception of involvement. (Watt, Reardon, and Bass, 1977).

There was no clear pattern of the effect of the parent involvement on outcome for either residence of the adolescents after discharge or their readjustment. Of the 15 children whose parents were involved, five had a good readjustment and five were rated as having a poor readjustment and five were unrated. Of the seven adolescents whose parents were less than involved, four were rated as having a good read-

justment, two had poor, and one case was unable to be located. Residence at follow up similarly showed no consistent relation to parent involvement. The lack of a simple relationship in the case examined appears to be due largely to the fact that most parents were classified as being involved on the basic of the rating system which could not differentiate differences. The findings, therefore, emphasized the need for a closer look at the issues raised above, rather than a conclusion that parental involvement is not important. (Watt, Reardon and Bass, 1977).

Cunningham and Barkley (1979) conducted a study involving the interactions of normal and hyperactive children with their mothers in free play and structural tasks.

The subjects included 20 groups which were normal and 20 that were hyperactive boys and their mothers who participated in the study. Children ranging chronological in ages, from 5 to 12 years, scored at least 80 on the Peabody Picture Vocabulary Test.

Observation sessions were conducted in a carpeted playroom equipped with ceiling microphones, one-way mirrors, and an adjacent observation room. Two chairs and a small table were centered in the room facing the observation mirror. For all children, a set of five toys was arrange identically on the table. These included: (a) a box of wooden blocks, (b) an etch-a-sketch board, (c) a box of large plastic tools, and (3) two boxes of lego blocks. (Cunningham and Barkley, 1979).

Children were observed interacting with their mothers in 15-min free play and 15-min structured-task situations. During free play, mothers were instructed to interact with their child, using any of the materials available, as they might at home if they had some spare time and were not expecting to be interrupted. In the structured-task situation, mothers were given a set of written instructions to have her child: (a) put away the toys and materials used in the free-play period, (b) copy a series of increasingly complex geometric figures, (c) complete a page of mathematic problems and geometric designs were selected to be consistent with the child's grade level. (Cunningham and Barkely, 1979).

The results indicated that mothers of normal children initialed significantly more social interactions during free play than those of hyperactive children, $t(39) = 3.59$, $p < .01$. Although both groups of children responded to a substantial proportion of those intiated by their mothers, hyperactive children proved significantly more responsive, $t(38) = 2.63$, $p < .02$. There were, however, no differences in the percentage of questions presented by either group of mothers or their children. The relative responsiveness of the normal and hyperactive children to the questions presented by their mothers did not differ. Although the percentage of social interactions initiated by the children responded to a significantly higher proportion of those interactions than the mothers of hyperactive children, $t(38) = 7.21$, $p < .001$. The results of the present study suggest that the behavior of the hyperactive children can be fully understood only within the context of the behavior of significantly individuals in his/her environment. (Cunningham and Barkley, 1979).

Wilton and Barbour (1979) conducted a study about mother and child interaction in a high-risk environment and contrast pre-schoolers of low socioeconomic status. They stated that children's activities with their mothers and the techniques used by mothers while interacting with their child were examined in older (30-46 months) and younger (12-27 months) low socioeconomic status pre-school children from high-risk and contrast homes. Older high-risk children interacted less often with their mothers and spent less time in "highly intellectual" activities than did the contrast children. The mothers of older risk children, in comparison with the contrast group, engaged less often in didactic teaching, showed less encouragement of their child's activities, and their attempts to control their child's activities more often resulted in failure. The differences between younger high-risk and contrast groups however were nonsignificant. (Wilton and Barbour, 1979).

Subjects were 10 pre-school siblings of Christ Church special-class pupils (the high-risk group) and 10 pre-school siblings of Christ Church regular-class pupils (the contrast group) and their mothers. (Wilton and Barbour, 1978).

The interaction with mother and child involved five interaction techniques. (1) teaching (e.g. mother reading to her child, mother showing child how to roll out Play-Doh with toy rolling pin), (2) facilitation (e.g. telling child not to touch iron because it is hot and will burn him/her, joining in child's play, showing approval and pleasure at a child's actions, pushing child on a swing, carrying child inside or outside), (3) routine talk, (4) observation, (5) restriction (spanking, scolding, etc.)

(Wilton and Barbour, 1978).

Wilton and Barbour (1978), summarized that only among the older children, the high-risk group interacted less with their mothers and participated less in activities which were highly intellectual than did the contrast group.

Anderson, Schlottman, and Weiner (1975), conducted a study to explore 22 biographical and psychological variables which were thought to have some bearing on frequency of family visits to the institution and attendance at parent conferences. The analysis identified 6 of the variables as significant predictors, although the factors related to the 2 measures of parental involvement were not identical. The 6 major predictors of lack of involvement were: presence of physical anomalies high disparity and social maturity; greater distance from the institution, low occupational level of the father, maintenance payments not being required, and the parent having custody, being divorced and remarried.

The data was provided from the Departments of psychology and social services of the Hisson Memorial Center (Sand, springs OK) provided data on 200 children and other families. The 22 biographical and psychological variables for which information was provided as as followed:

1. sex
2. age
3. length of institutionalization
4. race
5. mental age (MA)

6. IQ
7. social age
8. social quotient
9. anomalies (abvious physical stigmata associated with various syndromes e.g. Down syndromes, e.g. Down's syndrome, microcephaly, hydrocephaly, cerebral palsy, blindness)
10. family income (6 levels, ranging from less than 3,000 per year to greater than 15,000 per year)
11. distance of parental home from institution (6 levels, ranging from less than 20 to greater than 100 miles).
12. father's occupation (9 levels based on Wechsler's (1967) condensation of 2960 census groupings).
13. father's education
14. mother's education
15. parents married.
16. parents divorced and parent having custody living alone
17. parents divorced and parents having custody re-married
18. parent having custody widowed
19. parental status (natural or adoptive)
20. financial maintenance required and current payments.
21. financial contribution to child's maintenance required
22. financial maintenance required and delinquent in payments (Anderson, Schlottman, and Weiner, 1975).

Subjects were grouped into four categories based on attendance or nonattendance of parent conferences and frequency of visitations (often-once or more per month; seldom or never-three times a year or less). The attend-visit group (n=88) consisted of retarded children whose

parents attended the conference but visited their children seldom or never. The visit-do not attend group (n=14) consisted of retarded children whose parents did not attend the conference but invited their children often. The do notattend-do not visit attend the conference and visited their children seldom or never (Anderson, and Weiner, 1975).

Anderson, Schlottman, and Weiner (1975) utilized a three step-wise linear discriminant function analysis to examine differences between the attend-visit group and each of the other three criterion groups. The predicator variables used to differentiate the attend-visit group from each subjects on the 22 biographical and psychological variables.

The result of the study indicated that the mean vectors for attend-visit group and the attend-do not visit group were significantly different (F-22.86, 2/150 df, $p < .001$). Results showed that retarded children in the attend group had a higher social guotient (mean = 40.61) than retarded children in the attend-do not visit group (mean =25.02). In addition, a higher proportion (.38) of parents of the attend do not group children had maintenance not required compared to .15 of the parents of the attend-visit group and .72 of the attend-do not visit group subjects were statistically classified as the attend do not visit group (Anderson, Schlottman, and Weiner, 1975).

It was also found by Anderson, Schlottman and Weiner (1975), that when each of the 22 predictor variables were considered separately prior to the discriminant function analysis, 9 of the 22 had significantly differentiated the attend-visit group and the attend-do not visit group beyond the .05 level (see Table 2). Specifically, subjects whose

parents attended the conference but did not visit their children had lower MA, IQ, social age, and social quotient than subjects in the attend-visit group where there was a high incidence of phsycial anomalies among the subjects and a larger proportion of subjects for whom financial maintenance was not required from the parents. Families of attend-no visit group subjects, where there was a higher proportion of required financial maintenance.

The comparison that was made between the attend-visit group and visit-do not attend group showed the mean vectors for the attend-visit group and the visit do not attend group were significantly different ($F=7.81$, 3/98 df, $p < .001$). The families of the visit-do not attend group subjects tended to live farther from the institution to have a father in a lower occupational level, and to have a higher incidence of divorced and remarried parents than those of the attend-visit group. When the discriminant function was used with these three predictors, .76 of attend-visit group subjects were statistically classified as the visit-do not attend group (Anderson, Schlottman, and Weiner, 1975).

Anderson, Schlottman, and Weiner's (1975) reasoning behind the comparing of the attend-visit group and the attend-do not visit group was an attempt to determine those factors related to visitation. Parents in both groups attended parent conferences, but they differed in that in one group (attend-visit) they visited seldom or never. One of the main difference that was found between the groups were related to the characteristics of the child. Children who were functioning at a higher level of intelligence and

social maturity were more likely to be visited often. Klaber's (1968) observed that self-sufficient children are visited more. In addition, the low parental interest in institutionalized retarded children with physical handicaps noted by Hommond et. al. (1969) also gained statistical support in that the presence of physical anomalies was a significant factor differentiating the groups.

It was made clear in the study above that there was no way to determine whether parents with higher incomes who are required to contribute to their child's maintenance have a greater incentive to visit or whether low income presents an economic deterrent to visitation. However, it was found that the frequency of visits could be related to the distance parents have to travel to visit their children. The closer parents lived to the institution, the more they visited their children (Anderson, Schlottman, and Weiner, 1975).

The analysis revealed that two variables social quotient and the requirement of financial maintenance were considered to be the best predictors of visitation. Children with higher social quotient whose parents are required to make maintenance payments are likely to be visited often. The addition of other variables related to visitations, although important in their own right, did not increase the accuracy of predication (Anderson, Schlottman, and Weiner, 1975).

Byassee and Murrell (1975) conducted a comparative study where by six families with autistic children were compared with six families with disturbed children and six with normal children by means of a family interaction task.

However, they found that there were no difference between families with autistic children and those with normal children. Families with disturbed children were found to have less agreement between father & mother than did autistic or normal families.

The subjects of the included eighteen families who were of the caucasian race, and had at least, two children, one of whom was eight or older. The descriptions of the three families were as followed:

Austistic Families: The autistic child in each of these six families had a least one psychiatric or psychological diagnosis of early infantile autism had been enrolled in school for autistic children, and had general symptom characteristics including an set of psychosis prior to two years of age, severe speech or language abnormalities ritualistic or complusive behaviors, and failure to develop adequate interpersonal relationships (Byassee and Murrell, 1975).

Disturbed Families: These were families with children enrolled, past or present, at a residential school for children with behavioral and emotional difficulties. None of these children were autistic or psychotic, according to professional diagnosis. From sixteen volunteer families, the six most clearly matching the autistic family triads were chosen (Byassee and Murrell, 1975).

Normal Families: These were families picked from a membership list of a church and from names offered by colleagues participating in this research. It was emphasized that the family should have no member with criminal or emotional problems for at least the past five years, and that professionally sophisticated members would be ineligible.

Fourteen families indicated an interest in participating families were visited in their homes, at which time the Peabody Picture Vocabulary Test was administered to the target child (the normal sibling who would be participating in the family interaction task) within each sex category, for each family group, the ages and IQs for the target children were located on horizontal and vertical dimensions and the best matching three family clusters (one from each family group) were selected. Family socioeconomic status (SES) was quantified by chief income recipient into standard scores and taking a mean of the two scores. The mean family SES scores for the autistic family was 85.17 distrubed autistic family was 85.33. The families were called into a moderate income bracket, middle to upper-middle-class. Each group of families contained four male and two female target children. The mean ages for the children were 11.0 (autistic), 11.7 (disturbed) and 117 (normal). The Louisville behavior checklist was used to establish that the children who was labelled disturbed was, infact, disturbed (Byassee and Murrell, 1975).

Byassee and Murrell (1975) used an analysis of variance of the three target child groups, as well as the disturbed child group, on the four checklist scales of the Louisville Behavior checklist which showed no significant differences between the three target child groups, an showed them to have fewer behavior problems that did the identified child group. Thus, there were no significant differences among the three family groups in terms of the deviant behavior of the target children, and the three family groups were matched on SES scores, age, sex, and IQ of the target child.

Byassee and Murrell (1975) then finalized their findings (see Table 3 in appendix) which presents the unadjusted means for each family group and the F-ratios on each measures. Goldforb (1961), along with others found this findings to be true. He found families of organic schizophrenics (some of whom were autistic) to be equally as "adequate" in family interaction behavior as were autistic normal families. Byassee and Murrell (1975) made it clear that the severity of deviant behavior of children will be reflected in the severity of family abnormality. The finding also indicated that the spontaneous agreement between parents of disturbed families would indicate that these parents whether communicate less or have fewer common interests than do parents in the other in the other in the other two groups.

Finkelstein, (1974) focused his attention toward the family participation in residential treatment. He expressed several concerns: (1) What is it that residential treatment seeks to change? (2) If it is the child, how can he/she then return to a family system that has contributed to the counter productive behavior that prompted the original referral? (3) Is it the family? (4) How can we intervene with a family that will not allow us in? (5) If it is the entire family system, how can we enable it to effect change so that the needs of all members can be met, their communication hear, registered and appropriately responded to? Finkelstein (1974) felt that if these questions are dealt with effectively the stay in the residential treatment program could be shorten.

Finkelstein (1974), went on further to say that the key to successful parent involvement is the recognition of parental rights and strengths. It is up to the agency to mobilize these resources by using its own structure and a creative combination of programs and facilities. He quoted Alpert and Starr (1971) as saying that "it is the placing of primary responsibility for decision with parents that creates the anxiety necessary to help them resolve their ambivalence Once parents realize they cannot manipulate the placement agency by displaying their negative feelings about their child on to it, the chances of having parents accept responsibility for these feelings are greatly increased." Active parental involvement provides concrete evidence to the child that staff and family are working together, sharing their differences, and openly gaining support from each other.

These studies and articles were selected to show that parental involvement has been considered as an effective technique for working with problem children especially mental retarded, emotional disturbed, handicapped and others. Children like to know that they are the center of attention. They feel even more special when their (parent-s) take time to get involved in their well-being.

These studies that have been cited in this Review of Literature seldom made any reference to the ethnic backgrounds of its subjects. This is not to say, that no studies have been done utilizing Blacks and other minorities. However, it is known that when the subjects are from any ethnic background other than white, it is indicated somewhere in the study. The point that is being made is that the researcher is not trying to say that there were no studies done on Black and minorities, but few were revealed during this search.

CHAPTER III

Theoretical Foundation of the Study

The System Approach will be utilized as a theoretical foundation framework that one can use to understand the family network. The social system is seen as a subclass of systems in general. As such they are subject to the principles of general systems theory (GST). Jones (1980) quoted Bertlanffy, (1966) with the following words, "general systems theory contends that there are principles of systems in general or in defined subclasses of systems irrespective of the nature of systems of their components, or of the relations of focus between them."

Thus, the General System Theory is broad in that it attempts to examine all types of systems. A system is an organization of elements limited in the form of regular interaction and interdependence. General Systems Theory as an approach to organizing and looking at phenomena is thus applicable to the call (biological system), to the individual (psychological system), and to groups or society (social systems) (Jones, 1980).

The concept of a social system has been treated comprehensively by Talcott Parsons (1951; 1955). A social system is an aggregation of social roles or persons bound together by a pattern of mutual interaction and interdependence. It has boundaries which enables us to distinquish the internal from external environment, and typically, it is

both a system for social units smaller than itself, and a subsystem for social units larger than itself (Jones, 1980).

The Black family has been known as a social system which has been grossly over simplified by Billingsley (1968) in Figure 1 (see appendix). As depicted, the family is embedded in a network of mutually interdependent relationships within the Black community and wider society. Just as the Black family is a subsystem of the Black community, so are various patterns, in turn, a subsystem to the larger interactive pattern (dyad, triad, etc.) within the family (Jones, 1980).

A key consideration in all of this concerns in mutually interdependent relations existing between the family and its members on the one hand, and the Black community, on the other. It may be that among other things, the nature of the relationship of the family to the Black community is a key factor in development of the child's self-image (Jones, 1980).

Another theory utilized is Ivan Pavlov's theory on operant conditioning and modeling which is used in understanding behavior disorder. Throughout the twentieth century, psychologists accumulated ample evidence that behavior is largely controlled by its consequences. Some of the better known scientists who have studied the effects of the consequences of behavior include J.B. Watson, B.F. Skinner, and Neal Miller. It has been demonstrated that behavior that is followed by a reward or reinforcer is likely to be repeated. For example, if a hungry child discovers delicious cookes on top of the refrigerator, he/she is much more likely to climb on top of the refrigerator the next

time hunger pangs occur. If an infant is fed immediately upon crying, the probability of future crying is drastically increased. This is the principle of positive reinforcement and its plays a major role in the development of a child's behavior patterns. Effective reinforcers vary with the individual child. Some common reinforcers include candy, raisins, praise, money, television, hugs, kisses and attention. Behavior problems are learned when children are inadvertently reinforced for undesirable behavior. Attention, whether positive or negative, usually reinforces the behavior (Twiford, 1979).

Psychologists have learned that undesirable behavior can be decreased by ensuring that the behavior is not followed by a reinforcer. This procedure, called extinction, is extremely effective in eliminating inappropriate behavior. The most common usage of extinction involves simply ignoring the child when he/she is displaying an undesirable behavior. This approach, coupled with the positive reinforcement procedures is very effective in producing the desired behavior change (Twiford, 1979).

Another method by which behavior is modified through its consequences is punishment. This method suppresses behavior through the immediate application for an aversive stimulus to a specific response. Punishment may produce unwanted side effects thus, it should be reserved for situations in which a child physically endangers himself/herself or others (e.g., spanking a child for playing with matches). Typically this type of punishment can be looked at as a value judgement (Twiford, 1979).

Procedures that emphasizes learning through the consequences of behavior are called operant conditioning. Several types of operant conditioning are often combined and applied to several behaviors simultaneously, which result in an extremely complicated procedures. Such programs would most likely be designed by a behavioral psychologists. The important thing to remember is that most behavior disorders are learned and that they can be unlearned through procedures similar to thos mentioned above (Twiford, 1979).

Although some may disagree, all human behavior cannot be explained in terms of a learning theory. Such factors as genetics, biochemistry, and language seriously complicate simplistic explanations of behavior based on learning theories. Yet the advance made through research in classical and operant conditioning have yielded many valuable tools for the mental health professional...Therefore, a child's behavior is usually more susceptible to alteration, which is often readily achieved (Twiford, 1979).

Modeling is a form of learning in which a child acts in imitation of a social model. Although modeling is often explained in terms of operant learning, its importance demands special mention. The modeling process has unquestionable influence on the development of a child's behavior patterns (Twiford, 1979).

Such undesirable behavior patterns such as lying, stealing, aggression, or swearing are to some extent, attributable to poor models in the child's environment. Children are often observed imitating athletes, singers, and others whom they perceive as possessing status. The child learns

to imitate undesirable behavior as readily as desirable behaviors. Hence, the importance of ensuring that a child is surrounded by positive mdoels cannot be over emphasized (Twiford, 1979). The use of modeling has been used with the intention of providing a basis for understanding how certain behavior disorders develop in the child.

It is important for parents, teachers, and other professionals to be cognizant of how some behavior problems are learned. Although, some behavior problems may be more serious than others, proper diagnosis and referrals are critical for effective treatment. Finally, it has been demonstrated that negative labelling can be avoided in favor of observing and recording specific behavior patterns (Twiford, 1979).

The theories that were chosen in this section can help society to understand the relationship of the family to the Black community. The dynamics of systems theory enables us to take a holistic look at the family, child and community. Assessing the child without his/her family and/or total environment would not give a realistic picture of who the child is.

Utilizing learning theories toward the understanding of behavior can assist in the interpretation of behavior. Using operant conditioning and modeling theories along with system theory should prove to be useful in understanding, the Black child. It is therefore important for professionals to understand how they can apply the systems theory and various learning theories, to assure proper diagnoses and encourage more effective treatment programs.

ASSUMPTIONS

The researcher made the following assumptions:

1) That parents seldom hug or kiss their children.
2) That parents rarely tell their children that they love them.
3) That parents do not set aside time for family discussions.
4) That children do not confide in parents when they have a problem.
5) That children are not happy living with parents.
6) That the older a child gets the less likely he or she would receive physical affection.
7) That parental involvement is very low.

Hypothesis

The researcher proposes to show that there is no difference between the perception of family interaction by behavioral disordered children in Atlanta, Georgia and St. Thomas, Virgin Islands.

CHAPTER IV
METHODOLOGY

Sample and Selection Techniques

The subjects that were selected for this study came from a population of children diagnosed "behavioral disorderd." There was a total of one-hundred (100) subjects surveyed, all of whom were Black males and females ranging between the ages of 6-13 years.

There were two groups of subjects. Group I was selected from the Department of Health-Division of Mental Health-Children Serivces, located on St. Thomas United States, Virgin Islands. There were total of ninety-five (95) children enrolled at this agency. Only forty-five (45) were diagnosed "emotionally disturbed" or "child abuse". All forty-five of the children diagnosed behavioral disordered were used in the study. Within this group of subjects, 35 were males and 10 were females.

Group II, subjects were selected from a local agency within the Metro Atlanta area. In order to protect the identity of the participants the exact title of the program will be withheld. The total population of this agency was one-hundred and twenty five. Only fifty five (55) were diagnosed "behavioral disordered," all of whom were used in this study. Within this group of subjects, 43 were males and 12 females. Method of analysis. The researcher utilized the descriptive-comparative survey method of research. The interview technique was used to collect data for the study. The questionnaire instrument was designed by the researcher (see appendix A).

The interviewers of both groups were all employees of the identified agencies. Group I consisted of 10 interviewers, all of whom were trained by a psychologist. There were eight females and two males. In group II, there were fifteen interviewers, all of whom were trained by a mental health social worker (MSW). Ten of the interviewers were females and the remaining five were males. All of the twenty-five interviewers received between 15 to 20 hours training which covered general objectives of the survey, survey methods and interviewing techniques. Training and interviewing took placed in the identified agencies. (The rationale behind the use of so many interviewers was a means of speeding up the interviewing process.)

Administering of Questionnaire: The interviewing process was conducted over a two day period for Group I and a four day period for Group II. Fifteen minutes were allotted for each interview session. Before conducting any interviewing session, consent was granted on a prior therapy agreement between the subject's family and the identified mental health agencies. The consent was obtained during the intake session. Confidentiality was assured by guaranteeing anonymity of each individual subject and his/her agency.

Agencies Profile: Neither one of the agencies were institutions. In Group I, the younger subjects (6-10) were bused to the agency in the mornings and (Monday and Tuesday) left at 12:00 p.m. The older subjects were bused at 1:00, left at 3:30 p.m. (Monday and Tuesday).

Group II, the younger subjects were bused on Monday and Wednesday mornings. The older subjects attended sessions

on Tuesday and Thursday mornings.

Hypothesis: This study hypothesized that there is no difference between perception of family interaction by behavioral disordered children in Atlanta, Georgia and St. Thomas Virgin Islands.

Method of Analysis: The data was complied and tabulated manually by the researcher. A variety of statistical measures were used to analyze the data. Descriptive statistics such as frequencies, tables, precentages, and measures of central tendency were used.

Limitations: Although considerable effort was put forth to obtain a representative population the finding cannot be generalized to all children. In addition, there was, no way to validate whether the responses given by the children were the absolute truth.

In addition, due to time and funds, the researcher was unable to expand study to include "Normal subjects".

CHAPTER V

PRESENTATION OF RESULTS:

The data revealed that the hypothesis appears to be true based on the responses given by both groups of subjects.

TABLE 4A

Significant overall scores for age and birth order for males and females from Group I & II.

N=100

	GROUP I		GROUP II	
	MALE	FEMALE	MALE	FEMALE
BIRTH ORDER	1.5	2.5	1.9	3.0
MEAN AGE	8.8 years		9.0 years	
AGE	9.2 years	8.3 years	8.5 years	9.2 years

Table 4A shows that the overall, mean age for Group I was 8.8 years, the mean age for the males within this group was 9.2 years and for females 8.3 years. In Group II the overall mean age was 9.0 years. The mean age for the males within this group was 8.5 and for females, 9.2 years. The Table also shows that in Group I the median birth order for males was 1.5 and for females 2.5. In Group II the median birth order for males was 1.9 and for females 3.0.

TABLE 4B

Percentage breakdown of living arrangement of children with family.

N=100

	MOTHER	FATHER & MOTHER	GRANDPARENTS OR SOME OTHER RELATIVES	TOTAL
GROUP I	49%	31%	20%	100%
GROUP II	50%	39%	11%	100%

Table 4B shows that in Group I 49% of the children live with mother, 31% live with father and mother, and the remaining 20% live with grandparents or some other relatives. Fifty percent of the children from Group II live with only their mothers, 39% live with both father and mother and 11% live only with grandparents or some other relatives.

Table 5 revealed that 65% of the parents rarely demonstrated physical affection toward their children. (Shown on page 48).

TABLE 5

A frequency Distribution and percentage breakdown based on the response to question, #6, "Do your parent(s) hug or kiss you?"

	Virgin Island N=45 GROUP I		Atlanta, Georgia N=55 GROUP II	
Response	F	Percentage	F	Percentage
Never	6	13.4	4	7.2
Almost never	16	35.5	26	44.3
Sometimes	16	35.5	18	32.8
Almost always	7	15.6	6	10.9
Always	0	0	1	1.8
		100%		100%

TABLE 6

Responses to question, #7 "Do your parent(s) praise you when you do something good at home or at school?"

	N=45 Group I		N=55 Group II	
Response	F	Percentage	F	Percentage
Never	10	22.2	2	3.6
Almost never	21	46.7	30	54.6
Sometimes	12	26.7	20	36.4
Almost always	2	4.4	2	3.6
Always	0	0	1	1.8
		100%		100%

Table 6 indicated that 69% of the parents in St. Thomas did not or almost never praised their children. Comparatively over 50% of the parents in Group II from Atlanta, Georgia failed to consistently praise their children.

TABLE 7

Responses to question, #3, "How often do your parent(s) tell you they love you?"

	N=45 Group I		N=55 Group II	
Response	F	Percentage	F	Percentage
Never	11	24.5	3	5.5
Almost never	19	42.2	26	47.3
Sometimes	14	31.1	25	45.4
Almost always	1	2.2	1	1.8
Always	0	0	0	0
		100%		100%

Table 7 reflects that 69% of Group I and 53% of Group II responded that their parents rarely told their children that they were loved.

TABLE 8

Responses to question, #14, "When you have a problem at school do you feel your parent(s) listen to your side of the story?"

	N=45 Group I		N=55 Group II	
Response	F	Percentage	F	Percentage
Never	9	20.0	3	5.4
Almost never	24	53.1	30	54.6
Sometimes	12	26.7	22	40.1
Almost always	0	0	0	0
Always	0	0	0	0
		100%		100%

Table 8 revealed that all of the children (100%) from both groups felt that when they had a problem at school, parents might sometimes or almost never listen to their side of the story.

TABLE 9A

Response to question, #8 "Do you talk to your parent(s) when you have a problem?"

	N-45 Group I		N=55 Group II	
Response	F	Percentage	F	Percentage
Never	15	33.3	17	30.9
Almost never	20	44.5	23	41.8
Sometimes	9	20.0	14	25.5
Almost always	1	2.2	1	1.8
Always	0	0	0	0
		100%		100%

Table 9A dealt with level of communication between children and parents. Seventy-three percent (73%) of the children from Group I and 60% from Group II indicated that they did not share personal problems with parents.

TABLE 9B

Percentage of possible persons that subjects talked to when they had a problem.

	N=45 Group I	N=55 Group II
Possible persons that subject talked to when they had a problem.	Percent	Percent
Mother	2.0	1.5
Father	2.1	1.0
Aunt	25.5	20.9
Grandparents	15.4	19.9
Friend	30.5	19.9
Sibling(s)	10.0	42.2
Others	14.5	15.0
	100%	100%

Table 9B indicated that significant persons that were chosen as a means of confiding in from Group I usually chose a friend (31%) as a primary confidant and an aunt was often used as a second choice (26%). In comparison, Group II also chose a friend as a primary confidant (42%) and 21% chose an aunt as a secondary resources.

TABLE 10

Response to question, #15, "When you do have a problem at school, do your parent(s) go to school and talk with the teacher?"

	N=45 Group I		N=55 Group II	
Response	F	Percentage	F	Percentage
Never	6	13.3	8	14.0
Almost never	19	42.2	31	56.0
Sometimes	20	44.5	17	30.1
Almost always	0	0	0	0
Always	0	0	0	0
		100%		100%

Table 10 revealed that all of the children (100%) from both groups indicated that when they had a problem at school parent(s) might sometimes or almost never go to school and talk with the teacher.

TABLE 11

Response to question, #16, "Do you and your parent(s) go on family outings together?"

	N=45 Group I		N=55 Group II	
Response	F	Percentage	F	Percentage
Never	9	20.0	9	16.3
Almost never	27	6.0	26	47.2
Sometimes	9	20.0	20	36.3
Almost always	0	0	0	0
Always	0	0	0	0
		100%		100%

Table 11 addressed actual types of family interaction. The data revealed that Group I felt that 88% of their parents never went on family outings while Group II responded that 64% of their parents never went on family outings.

TABLE 12

Responses to question, #17, "Do your parent(s) set aside time for family discussions?"

	N=45 Group I		N=55 Group II	
Response	F	Percentage	F	Percentage
Never	28	62.2	20	36.3
Almost never	16	35.5	24	43.6
Sometimes	1	2.3	11	20.1
Almost always	0	0	0	0
Always	0	0	0	0
		100%		100%

Table 12 indicated that 98% of the parents of Group I respondent did not set aside time for family discussions while a significant 80% of Group II's parents did not either.

TABLE 13

Responses to question, #18, "Do you feel your parent(s) pay attention to you when you talk to them?"

	N=45 Group I		N=55 Group II	
Response	F	Percentage	F	Percentage
Never	13	28.9	9	16.3
Almost never	19	42.2	27	49.1
Sometimes	13	28.9	19	34.6
Almost always	0	0	0	0
Always	0	0	0	0
		100%		100%

Table 13 indicated that all of the children (100%) from both groups felt that parent(s) do not pay attention to them when they (children) talk to them.

TABLE 14

Responses to question, #20, "Do you feel your parent(s) like you?"

	N=45 Group I		N=55 Group II	
Response	F	Percentage	F	Percentage
Never	5	11.5	10	18.2
Almost never	24	53.4	36	65.4
Sometimes	14	31.1	9	16.4
Almost always	2	4.4	0	0
Always	0	0	0	0
		100%		100%

Table 14 addressed the issue of satisfaction of subjects with their family structure. In Group I (64%) and Group II (83%) stated that they did not feel as if their parents liked them.

TABLE 15

Response to question, #21, "Are you happy living with your parent(s)?"

	N=45 Group I		N=55 Group II	
Response	F	Percentage	F	Percentage
Never	1	2.2	4	7.8
Almost never	15	33.4	30	54.5
Sometimes	28	62.2	21	38.2
Almost always	1	2.2	0	0
Always	0	0	0	0
		100%		100%

Table 15 reflected that 64% of the children from Group II indicated that they were not happy living with parent(s) and only 36% of Group I were not happy living with their parents.

TABLE 16

Responses to question, #23, "Do you feel your parent(s) are happy with you living with them?"

		N=45 Group I		N=55 Group II
Response	F	Percentage	F	Percentage
Never	1	2.2	8	14.5
Almost never	15	33.4	16	29.1
Sometimes	28	62.2	31	56.4
Almost always	1	2.2	0	0
Always	0	0	0	0
		100%		100%

Table 16 revealed that 35% of the children from Group I felt that parent(s) were not happy living with them and 44% of the children from Group II felt that their parents were unhappy living with them.

TABLE 17

Percentage breakdown of the different methods of discipline used by the parent(s) of the "tested" children.

	N=45 Group I	N=55 Group II
Methods of Discipline	Percent	Percent
Spanking	50.0	59.0
Priviledges taken away	14.0	10.0
Talking mean or yelling at you	5.0	7.5
Talking nice	3.0	3.9
Ordered to your room	10.0	7.2
Ignored	18.0	12.4
Others	0	0
	100%	100%

Table 17 revealed that 50% of the parents from Group I and 59% of Group II utilized spanking as a viable means of discipline as opposed to talking to the child in a "nice" manner.

TABLE 18

Percentage breakdown of several ways children express anger.

	N=45 Group I	N=55 Group II
Different ways that the children used in handling anger	Percent	Percent
Fighting	40.2	40.5
Going off by yourself	25.0	34.0
Hitting something	15.0	10.8
Thinking about it	5.9	7.2
Cries	10.1	2.0
Steals	2	1.0
	100%	100%

Table 18 revealed that 42% of the children in Group I and 45% of the children in Group II use fighting as a means of effectively dealing with anger. The table also revealed that in group I only 5.9% and in group II 7.2% of the children usually tought about their anger.

TABLE 19

Percentage breakdown of ways parent(s) handle anger with each other.

	N=45 Group I	N=55 Group II
Ways in which parent(s) act when angry with each other	Percent	Percent
Argue	46.0	50.5
Physically fight with each other	9.0	30.0
Talking nice to each other	12.0	5.0
Take it out on you	7.1	10.0
Child and/or sibling(s)	0	0
Does not apply	0	0
	100%	100%

Table 19 revealed over 70% of the parents in Group I and 81% in in Group II stated that their families argued or fought to resolve angry feelings.

TABLE 20

Percentage responses by the children of the different ways they handle anger with parents.

Ways child handle anger with parent(s)	N=45 Group I Percent	N=55 Group II Percent
Talk with them	10.9	20.5
Cry	29.9	25.4
Scream at them	23.8	9.1
Don't talk	35.4	45.0
Run away	0	0
	100%	100%

Table 20 indicated that 35% of the children of Group I and 45% of Group II typically "don't talk" when they are angry with their parents. Only 10.9% of group I and 20.5% in group II talked with parents when they are angry.

TABLE 21

Percentage breakdown of ways parent(s) show their love for their children.

Ways parent(s) show their love	N=45 Group I Percent	N=55 Group II Percent
By giving you gifts	39.9	40.9
By taking you on trips	2.5	3.9
By telling you they love you	1.0	15.2
By spanking you	15.9	13.0
By taking you out to different places	5.8	.4
By spending time with you	5.0	3.5
They don't	20.9	19.5
	100%	100%

Table 21 indicated ways in which parent(s) showed their love. Forty percent of the subjects in Group I stated that their parents gave them gifts. Similarly, 41% in Group II's subject concurred with this response.

TABLE 22

Percentage breakdown to question, #6, "Do your parent(s) hug or kiss you?" By age.

N=45

Group I

Possible age category

Response	6-8	9-11	12-3	Total
	Percent			
Never	4.4	2.2	6.6	
Almost never	4.4	24.0	6.6	
Sometimes	15.5	12.0	8.0	
Almost always	5.2	11.1	0	
Always	0	0	0	
	29.5	49.3	21.2	100%

TABLE 23

Percentage breakdown to question, #6, "Do your parent(s) hug or kiss you?" By age.

N=45

Group II

Possible age category

Response	6-8	9-11	12-3	Total
	Percent			
Never	2.0	3.2	2.0	
Almost never	12.0	18.0	17.2	
Sometimes	4.2	12.5	16.1	
Almost always	5.1	3.2	2.6	
Always	1.8	0	0	
	25.2	36.9	37.9	100%

Table 22 and 23 (page 65) revealed that physical affection tended to decrease with the age of the children in Group I and increase with age in Group II. Table revealed that 16% of the children between the ages of 6 and 8 received more physical affection than the 9 to 11 years or 12 to 13 years old children . In contrast, table 22 revealed that 12 to 13 years old (16%) received physical affection more so than 9 to 11 (13%) years old or 6 to 8 years old(4%). This appears to be the one major difference in data obtain from the two samples.

DISCUSSION

The findings from this study showed some interesting results. It was very significant to find that male subjects from both groups were first born. There are many theories about birth order and one cannont help but wonder, what the social and psychological environment are like for the first born. Are first born children, especially males, pressured to succeed more in life than the second or third born? Do families and society expect the impossible from the first born? How does the preparatory stage different for the first born and other siblings? These are only a few of the questions that need to be answered to determine if the oldest child is born into excessive stressful situations.

Being a parent is a hard job. Parenting does not stop after the child is born or even after the child is old enough to take care of himself or herself. Therefore, it is important that parents try to do the best job they can. This point is made based on the fact that 50% of the children in this study expressed that their parents rarely demonstrated physical affection towards them. Regardless, if a child is good, bad, or indifferent, that is no excuse to withold physical affection. What happens to a child when he/she is not given love and affection? Has this child learned how to love and give love? In society, there are too many people searching for the meaning of love, because as a child it was withheld from them.

It is hard being a child because he/she has to depend on others for his/her livelihood. However, after obtaining the findings from this study, it is sad to know that children do not share personal problems with parents, do not feel their parents like them or are unhappy with children living with them. When a child has to each out for attention, love and affection from the one's he/she cares about and does not get it, then the child becomes vulnerable. The child will then seek else where for the love, attention and affection, he/she could not receive early in life. Drug abuse, alcohol abuse, delinquency etc. are some of the ways that children tend to satisfy their needs that were denied by his/her family members.

What kinds of model are parents giving their children as it pertains to discipline and for handling anger. When parents are too quick to spank as oppose to talking, what kind of message is the average child receiving? According to the data obtained from this study over 50% of the subject's parents utilized spanking as a primary form of discipline. Along the same line; over 70% of the parents argue or fought to resolve personal feelings of anger. Again, parents are showing their children that hitting is the best way of resolving conflict. This might further explain why over 40% of the children from both groups used fighting as a means of effectively dealing with anger. Thus, can the child be unconditionally blamed for demonstrating inappropriate behaviors? The old saying is true, we learn what we experience.

CONCLUSIONS

The findings of this study were based on the perception of how "behavioral disordered" children preceived family interaction. The researcher concludes that based on the findings that little if any interaction goes on in the families that were surveyed. However, the researcher cannot state that because parents do not interact with their children mean they do not love them. There can be many reasons for limited interaction between parents and children. One major reason could be that Black families are forced into the work field and simply do not have the time to interact as much as they would like. This might account for why 39.9% of the parents give gifts as oppose to spending time with their children. The question then becomes are gifts being substituted for not spending time with the children?

The destiny of a child's life is in the hands of adults. Whether, we realize it a child's behavior is a result of our action and interaction with him or her. If negative feelings are projected a negative response will be returned, and the same pattern occurs with positive feelings.

Black families with children diagnosed behavioral disordered, mentally retarded, illiterate, etc. which tend to cripple Black children should seek a second professional opinion. Families need to interact with their children, regardless of what the second consultation result indicates. Taking the time might be asking too much from some families, but sometimes families might have to make sacrifices when our children are crying out for help. Who said being a parent was easy?

At the same time, the researcher is not generalizing the findings to suit all children. The data can only be used to explain those behavioral disordered children that have been tested from those agencies identified earlier in the paper. However, further studies might look into a more in-depth work with "normal" children versus behavioral disordered children to increase external validity and reliability of the results.

Recommendation for Future Study

1) The self-esteem of behavioral disordered children needs to be looked at to determined whether low self-esteem is a characteristic of these children.

2) A need for follow-up study based on the findings to see if increased parental involvement would be more effective as an adjunct therapeutic aid with life.

3) There is a need to establish new policies whereby parental involvement is mandatory when a child is involved in therapy.

4) There is a strong need for developing courses for the purpose of training professionals in working with parents/guardian.

APPENDIX

A

FAMILY INTERACTION SURVEY FOR CHILDREN

The purpose of this survey is to assess the degree of interaction between children and family members.

1. What is your present age? _____

2. What is your birth order? _____

3. Number of relatives living in the household? _____

4. Number non-relatives living in the household? _____

5. What is your sex? _____Male or _____Female

Check the appropriate answer for the following questions:

6. Do your parent(s) hug or kiss you?

_____never
_____almost never
_____sometimes
_____almost always
_____always

7. Do your parent(s) praise you when you do something good at home or at school?

_____never
_____almost never
_____sometimes
_____almost always
_____always

8. Do you talk to your parent(s) when you have a problem?

_____never
_____almost never
_____sometimes
_____almost always
_____always

9. If the answer to question #8 is Never, why? _____ _____. Specify to whom do you talk? _____

10. How do your parent(s) act when they are angry with each other?

_____argue
_____physically fight with each other
_____talk nice to each other
_____leave the room
_____take it out on you (child) or your sibling
_____other (Specify) _____
_____does not apply

11. How do you handle anger?

_____fighting
_____going off by yourself
_____hitting something (i.e. pillow, door)
_____thinking about it (your anger)
_____other (Specify) _____

12. Do you and your brother(s) and sister(s) do things together?

_____never
_____almost never
_____sometimes
_____almost always
_____always

13. How often do your parent(s) tell you they love you?

_____never
_____almost never
_____sometimes
_____almost always
_____always

14. When you have a problem at school do you feel your parent(s) listen to your side of the story?

_____never
_____almost never
_____sometimes
_____almost always
_____always

15. When you have a problem at school, do your parent(s) go to school and talk with the teacher?

_____never
_____almost never
_____sometimes
_____almost always
_____always

16. Do you and your parent(s) go on family outings together?

_____never
_____almost never
_____sometimes
_____almost always
_____always

17. Do your parent(s) set aside time for family discussions?

_____never
_____almost never
_____sometimes
_____almost always
_____always

18. Do you feel your parent(s) pay attention to you when you talk to them?

_____never _____sometimes _____always
_____almost never _____almost always

19. How are you disciplined?

_____spanking
_____priviledges taken away (i.e. watching T.V., going to the movies etc.)
_____talking mean or yelling at you
_____talking nice
_____ordered to your room
_____ignored
_____other (Specify) _____

20. Do you feel your parent(s) like you?

_____never
_____almost never
_____sometimes
_____almost always
_____always

21. Are you happy living with your parent(s)?

_____never
_____almost never
_____sometimes
_____almost always
_____always

22. How do you handle anger with your parent(s)?

_____talk with them
_____cry
_____scream at them
_____other (Specify) _____

23. Do you feel your parent(s) are happy with you living with them?

_____never _____almost never _____sometimes
_____almost always _____always

24. Who do you live with?

_____mother and father
_____mother
_____father
_____grandparent(s)
_____other (Sepcify) _____

25. How do your parent(s) show their love?

_____by giving you gifts
_____by taking you on trips
_____by telling you they love you
_____by spanking you
_____by taking you out to different places
_____by spending time with you
_____other (Specify) _____

THE FOLLOWING QUESTION IS OPTIONAL.

26. What do you usually snack on before, between, or after meals?

_____candy
_____potato chips etc.
_____cookies
_____soda
_____apples, oranges, etc.
_____other (Specify) _____

28. Is mother in treatment with child? ____yes ____no
29. Is father in treatment with child? ____yes ____no
30. Are parents/guardian in treatment with child? ____yes ____no.

APPENDIX

B

TABLE 1

NEGRO FAMILY STRUCTURE

TYPES OF FAMILY	HOUSEHOLD HEAD		OTHER HOUSEHOLD MEMBERS		
	HUSBAND & WIFE	SINGLE PARENT	CHILDREN	OTHER RELATIVES	NON-RELATIVE
NUCLEAR FAMILIES					
I. Incipient	x				
II. Simple Nuclear Family	x		x		
III. Attenuated Nuclear Family		x	x		
EXTENDED FAMILIES					
IV. Incipient Extend-	x			x	
V. Simple Extended Family	x		x	x	
VI. Attenuated Extended Family		x	x	x	
AUGMENTED FAMILIES					
VII. Incipient Agument-ed Family	x				x
VIII. Incipient Extend-ed				x	x
Augmented Family	x			x	x
IX. Nuclear Agumented Family	x		x		x
X. Nuclear Extended Augmented Family	x		x	x	x
XI. Attentuated Augmented Family		x	x		x
XII. Attenuated Extend-Augmented Family		x	x	x	x

(Billingsley, 1968)

TABLE 2

MEANS AND STANDARD DEVIATIONS (SDs) OF PREDICTORS WHICH SIGNIFICANTLY DIFFERENTIATED BETWEEN GROUPS IN AT LEAST ONE ANALYSIS

Predictor	GROUP *Attend and visit Mean	SD	Attend Only Mean	SD	Visit Only Mean	SD	Neither Mean	SD
5. MA (months	46.66	22.96	28.05***	28.26	44.79	33.66	33.65	32.4
6. IQ	34.90	16.22	21.12***	19.28	32.07	21.97	27.34*	21.8
7. Social age (months)	58.09	29.81	33.63***	33.08	57.00	45.10	46.85	43.1
8. Physical quotient	40.61	17.95	25.02***	21.24	38.00	26.77	33.70	25.5
9. Physical anomaly (1=present. 0=absent)	.32	.47	.52*	.50	.36	.50	.73***	.4
10. Family income (5=high, 0=low)	2.56	1.66	1.94*	1.54	1.29**	1.20	1.18***	1.1
11. Distance from institution (6=far, 1=close)	1.60	1.02	2.08*	1.37	2.50**	1.70	2.76***	1.6
12. Occupation of father (0-to 9, 9=unemployed)	4.16	2.07	4.49	2.57	6.21**	2.04	6.18***	2.7
13. Education of father (years)	11.52	3.27	11.32	3.72	10.43	2.47	9.85*	3.6
14. Education of mother (years)	11.44	2.15	10.85	2.52	10.36	3.05	10.18*	3.1
15. Married = 1 (Others = 0)	.73	.43	.69	.47	.57	.51	.42**	.5
16. Divorced/alone =1 (Other = 0)	.12	.33	.15	.36	.00	.00	.30*	.4
17. Divorced/remarried=1 (Other = 0)	.10	.30	.11	.31	.36**	.50	.15	.3
20. Financial maintenance Not required=1 (Other = 0)	.15	.36	.38***	.49	.43*	.51	.58***	.5
21. Financial maintenance required and current payments made 1 (Other = 0)	.53	.50	.32**	.47	.36	.50	.24**	.

* Significantly different from mean of attend and visit group, $p < .05$
** Significantly different from mean of attend and visit group, $p < .01$
*** Significantly different from mean of attend and visit group, $p < .001$

*N=88 ** N=65 ***N=14 ****N=33

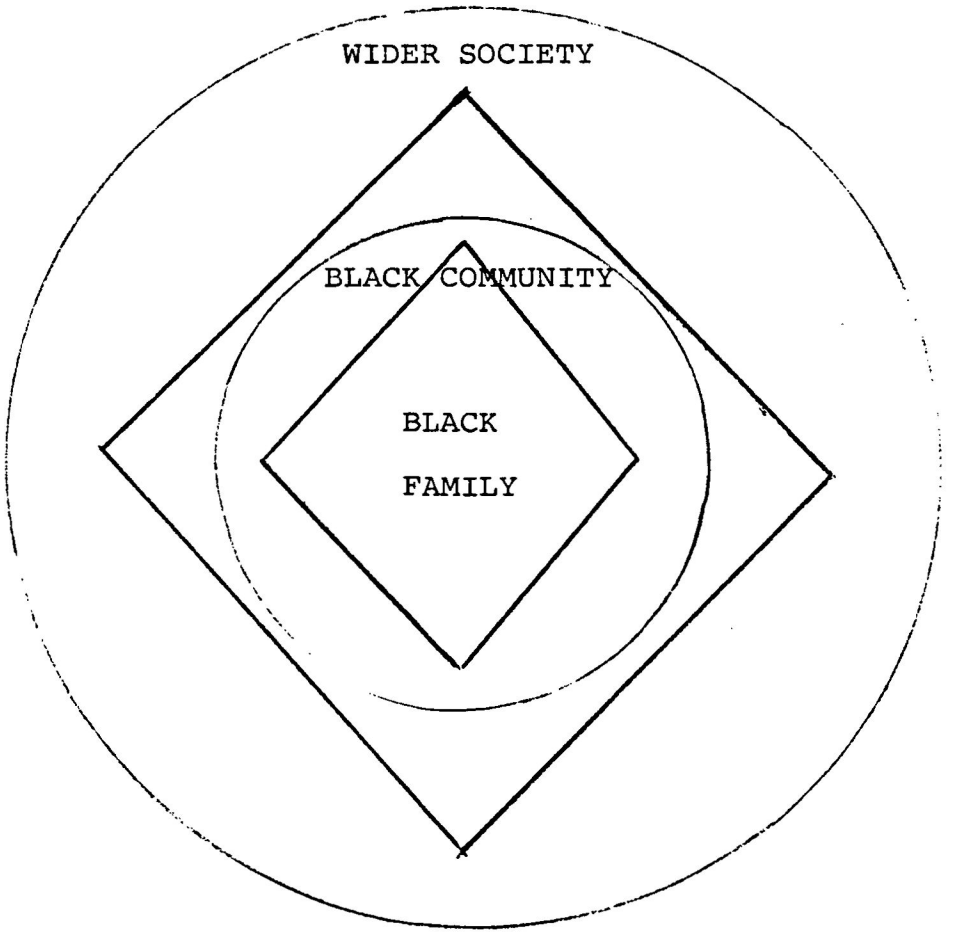
Table 3

MEANS AND F-RATIOS FOR AUTISTIC, DISTRUBED AND NORMAL FAMILIES

MEASURE	AUTISTIC FAMILY $\bar{X}$	DISTURBED FAMILY $\bar{X}$	NORMAL FAMILY $\bar{X}$	F-Ratio	df
Spontaneous Agreement-Family	65.00	60.50	65.67	.61	17
Father-Mother	25.17	19.67	27.33	8.09[b]	17
Father-Child	19.33	22.00	19.00	1.37	17
Mother-Child	20.50	18.83	19.33	.31	17
Father-Mother-Child	12.00	10.50	11.81	.42	17
Decision-Making Time	22.83	28.83	93.33	.04[a]	16
Choice Fulfillment-Family	91.50	85.83	93.33	.10[a]	16
Father	33.00	29.33	34.33	.06[a]	16
Mother	31.33	28.17	33.33	.18[a]	16
Child	27.17	27.50	25.67	.21[a]	16
Index of Normality	125.50	105.04	133.83	.30[a]	16

a Analysis of covariance
b $p1 < .01$

FIGURE 1

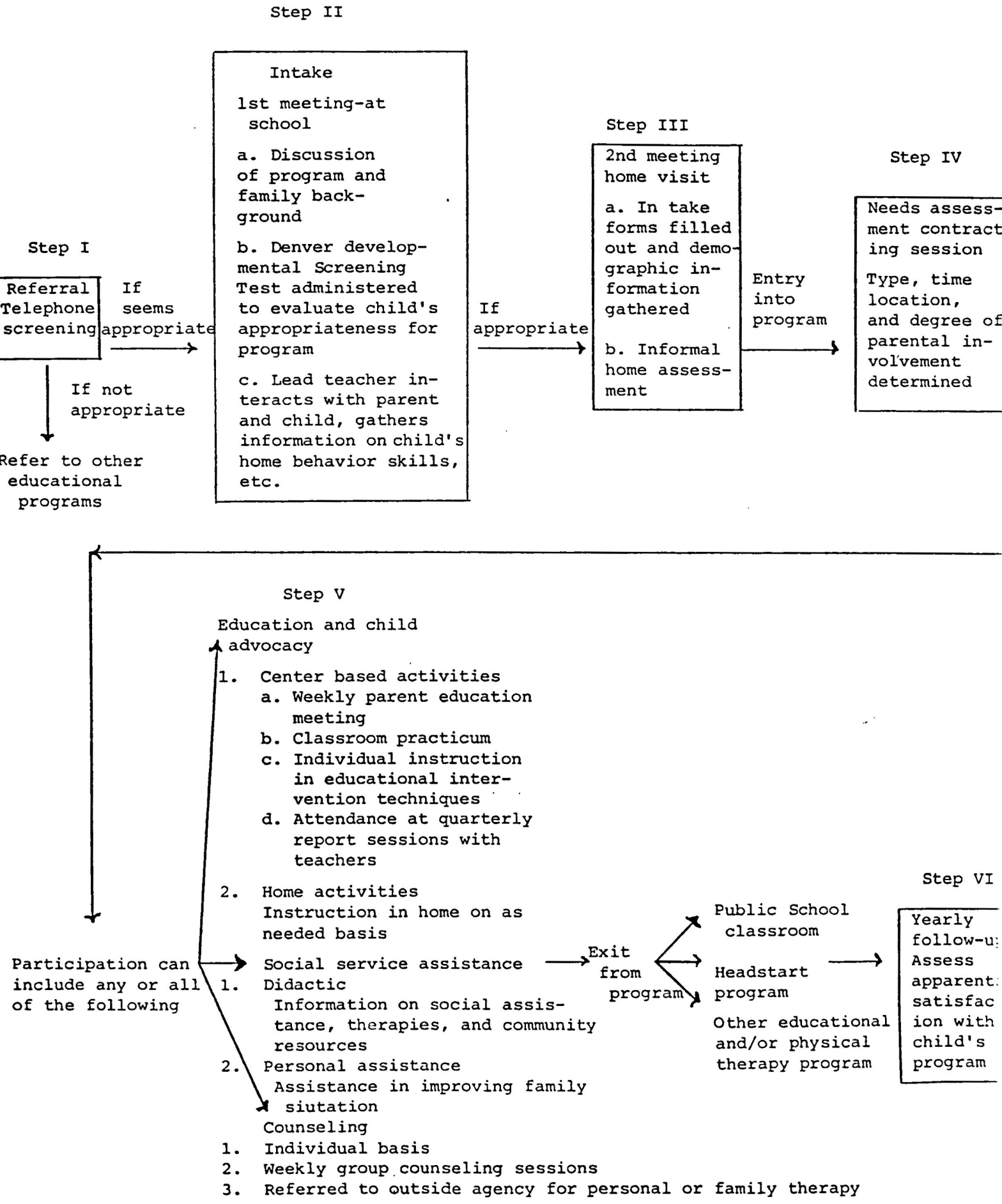


The Black family as a social system.
The family is embedded in a matrix of mutually interdependent relationships with the black community and the wider society. And there are several subsystems within the family: husband-wife, mother-son, father-daughter; grandmother-mother daughter, and so forth.

The black community includes schools, churches, lodges, social clubs, funeral societies, organized systems of hustling, other institutions.

The wider society consists of major institutions: values, policital, economic, health, welfare, and communication sub-systems. (Adapted from A. Billingsley, Black Families in White America, Englewood Cliffs, N.J.: Prentice-Hall, 1968) p. 44

FIGURE 2 Schematic of procedural steps from entry to exit from the program.



FLOW CHART

DATE OF PROCEDURES

PROCEDURES	JULY-81	AUGUST-81	SEPTEMBER-81	OCT.	NOV.	DEC.	JAN.	APRIL
SUBMIT PROPOSAL	X							
SAMPLE SELECTION	X							
QUESTION-NAIRE ADMINISTER								
EVALUATION AND ANALYSIS			X					
FIRST DRAFT					X			
FINAL DRAFT								X

REFERENCES

Anderson, Ralph E., and IRL Carter Human Behavior in the Social Environment - a social system approach. New York: Aldine Company, 1978.

Anderson, Victor, Schlottman, R., and Weiner, Barbara J. "Predictors of Parent Involvement with Institutional Retarded Children" American Journal of Mental Deficiency. Vol. 79 no. 6, 1975.

Anthony E. James, and Koupernik ed. The Child is His Family New York: John Wiley and Sons, Inc., 1970.

Billingsley, Andrew. Black Families in White America. New Jersey: Prenticehall, Inc. 1968.

Blassingame, John W. The Slave Community. New York: Oxford University Press, Inc., 1978.

Bowen, Murray. Family therapy in Clinical Practice. New York Jason Aronson, Inc., 1978.

Bricklin, Barry and Bricklin, Patricia M. Strong Family, Strong Child, New York: Delacorte Press, 1970.

Byassee, James E. and Murrell, Stanley A., "Interaction Patterns in Families of Autistic, Disturbed, and Normal Children," American Journal of Orthopsychiatry. 45 (3), April, 1975.

Comer, James P. and Poussaint, Alvin F. Black Child Care. New York: Pocket Books, 1975.

Cowley, Au-Deane S. The Family Integration and Mental Health. San Francisco, Cal.: R & S Research Associates, Inc., 1978.

Cunningham, Charles E. and Barkley, Russell A., "The Interaction of Normal and Hyperactive Children with their Mothers in Freeplay and Structured Tasks," Child Development, vol. 50, 1979.

Davis, Lenwood G. The Black Family in the United States, A Selected Bibliography of Annotated Books, Articles and Dissertations on Black Families in America. Conn: Greenwood Press, 1978.

Doxiadis, Spyros ed. The Child in the World of Tommorrow New York: Pargamon Press, 1979.

Elmer, Elizabeth. Children in Jeopardy. Pittsburgh, Pa.: University of Pittsburgh Press, 1977.

Finkelstein, Ehrlich. "Family Participation in Residential Treatment," Child Welfare vol. LIII, number 9, 1974.

Frazier, E. Franklin. The Negro Family in the United States. Chicago: The University of Chicago Press, 1973.

Freud, Anna, Watson, John B., Piaget, Jean, Mahler, Margaret, Wel, Annemarie and Buhler, Charlotte. The process of Child Development. New York, New York: New American Library, Inc. 1976.

Gambrill, Eileen D. Thomas, Edwin J., and Carter, Robert D. Proceedure for Sociobehavioral Practice in Open Settings," Social Work, January, 1971.

Gary, Lawrence E. Social Research and the Black Community: Selected Issues and Priorities. Washington, D.C. 1973.

Gary, Lawrence E. Mental Health-a challenge to the Black Community. Philadelphia and Aridmor, Pa.: Dorrance & Company, 1978.

Glass, Joel B. "Family Therapy: an Overview," Social Issues Resources Series. vol. 1, article #32, Philadelphia, 1974.

Goldfarb, W. Childhood Schizophrenia. Harvard University Press Cambridge, Mass., 1961.

Harlow, Harry F. and Mears, Clara, The Human Model: Primate Perspectives, New York: John Wiley & Sons, 1979.

Helen Featherstone, A Difference in the Family. New York: Basic Books, Inc., 1980.

Heiting, Kenneth H. "Involving Parents in Residential Treatment of Children," Children, vol. 18, number 5, September, 1975.

Hill, Robert B. The Strengths of Black Families. New York: Emerson Hall Publishers, Inc. 1972.

Jones, Reginald L. Black Psychology. New York: Harper and Row, Publishers, 1980.

Ladner, Joyce A. The Death of White Sociology. New York: Vintage Books, 1973.

Lidz, Theodore. The Person. New York: Basic Books, Inc., Publishers, 1976.

McLoughlin, James a Edge, Denzil and Strenecky, Bernard, "Parent Involvement: A consumer Perspective - in the clinic, Education and Training of the Mentally Retarded", December, 1978.

Murphy, Albert T., "In Support of Families," Alexander Graham Bell, Association for the Death, Inc. Washington, D.C.

Myers, Patricia I. and Hamill, Donald D., Method of Learning Disorders. New York: John Wiley and Sons Inc., 1976.

Peairs, Lillian and Peairs, Richard H., What Every Child Needs. New York: Harper & Row, Publishers, 1974.

Padilla, Amado M. and Ruiz, Rene A. Latino Mental Health, a review of literature. Maryland: 1973.

Redl, Frit and Wineman, David, Control from Within, New York: The Free Press, 1952.

Ross-Harrison, Phyllis and Wyden, Barbara, The Black Child. New York: Berkley Publishing Corporation, 1973.

Ross, Murray G. Community Organization: Theory, Principles Practice. 2nd. ed. New York: Harper & Row, 1967.

Slater, Mary D., Ainsworth, Mary C., Blehar, Everett, Waters, and Wall, Sally, Patterns of Attachment. New Jersey: Lawrence ERL Baum Associates, Publishers Hillsdale, 1978.

Saul, Leon J. The Childhood Emotional Pattern and Maturity. New York, Van Nostrand Reinhold Comp., 1979.

Smith, Lendon H. Improving Your Child's Behavior Chemistry. New Jersey: Prentice-Hall Inc., 1976.

Stewart, Alpert and Starr, Phillip, "A Family Centered-Approach to the Treatment of Emotionally Disturbed Children in Placement," Forum for residential Therapy, 11, 4, Spring, 1971.

Stone, L. Joseph and Church, Joseph. Childhood and Adolescence. New York: Random House, 1979.

Strenecky, Bernard J., McLoughlin, and Edge Denzil "Parent Involvement: A consumer perspective", February, 1979.

Sugarman, Betty A. "Atypical Children: Perspectives on Parental Professional Interaction - Social Case-work:" The Journal of Contemporary Social Work, 1979.

Twiford, Raine. A Child With A Problem. Englewood Cliffs, New Jersey: Prentice-Hall Inc., 1979.

Willie, Charles V., Kramer, Bernard M., and Brown, Bertram S., Racism and Mental Health. Pittsburgh, Pa: University of Pittsburgh Press, 1973.

Wilson, Amos N. The Developmental Psychology of the Black Child, New York, New York: African Research Publications, 1978.

Wilton, Keri, and Barbour, Ann, "Mother-Child Interaction in High-Risk and Contrast Preschoolers of Low Socio-economic Status," Child Development, University of Chicago Press, vol. 49, 1978.

Younghusband, Eileen. Case-work with families and Children. Chicago: University of Chicago Press, 1970.

Families Today, Science Monographs U.S. Department of Health, Education, and Welfare, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, 1979.

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The undersigned has examined a Substantive Paper entitled:

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Presented by Sylvia Monadene Buntin,

a candidate for the degree of Master of Social Work, and hereby certifies that in his/her opinion it is worthy of acceptance.

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